VERMONT

Department of Vermont Health Access
312 Hurricane Lane, Suite 201
Williston, Vermont 05495

BURPREN.1
FORM#04
C: 12.14

Agency of Human Services

~BUPRENORPHINE~

Prior Authorization Request Form (Spokes/OBOTS)

In order for beneficiaries to receive Medicaid coverage for medications that require prior authorization, the prescriber must telephone or complete and fax this form to Goold Health Systems. Please complete this form in its entirety and sign and date below. Incomplete requests will be returned for additional information.

Submit request via: Fax: 1-844-679-5366 or Phone: 1-800-679-5363

Prescribing physician:

Name: _____
Phone#:_____
Fax#: _____
Address: _____
Contact Person at Office: _____

Beneficiary:

Name: _____
Medicaid ID#:_____
Date of Birth: _____ Sex: _____
Pharmacy Name_____
Pharmacy Phone: _____Pharmacy Fax: _____

Anticipated maintenance dose/ frequency (target dose ≤ than 16 mg/day) (maximum 14 day supply per prescription fill)

Dose: _____Dosage Form (e.g. Film):_____Frequency :_____(recommended once daily)

Is buprenorphine being prescribed for opiate dependency?	€Yes € No
Has the prescriber queried the VPMS (Vermont Prescription Monitoring System) to review patient's scheduled II-IV medication history?	€Yes € No € Not signed up
Does the prescriber signing this form have a DATA 2000 waiver ID ("X-DEA license")?	€Yes € No
A "Pharmacy Home" for ALL prescriptions has been selected AND discussed with the patient? (Pharmacy must be located/licensed in VT) Pharmacy Name: _____ Pharmacy Phone#: _____	€Yes € No
Has patient filled a Suboxone RX in the last 60 days	€Yes € No € Don't know
If this request is for Buprenorphine (formerly Subutex®), please answer the following questions: Is the member pregnant? (please provider positive pregnancy test copy) If yes, anticipated date of delivery: _____	€Yes € No
Is the member breastfeeding a methadone or morphine dependent baby? (please provider history from neonatologist or pediatrician)	€Yes € No
Would you have referred your patient to a methadone clinic if this option was conveniently located and available?	€ Yes € No
Additional clinical information to support PA request: (please attach if necessary)	

By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in your medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.

Prescriber Signature:_____XDEA License#:_____ Date of request:_____

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